Westford Health Department 2010-2011 Flu Vaccine Consent Form

Child's Name (print):_____ Child's Age:_____ Grade:_____

Child's School :_____ Cluster, Homeroom, or Teacher:_____

Child's Primary Care Physician (PCP):_____ PCP Phone:_____

Fill out one sheet for each child.

All questions MUST be answered or your child will NOT be vaccinated!

1. Is your child allergic to eggs or egg protein? YES NO
2. Is your child allergic to gentamicin, gelatin, or arginine? YES NO
3. Has your child ever had Guillain-Barre syndrome? YES NO
4. Has your child received a flu vaccination in a **prior year**? YES NO
5. Has your child ever had a life threatening reaction to flu vaccine? YES NO
6. Has your child received **any other** vaccines within **the past month** (**ie.: MMR, chicken pox, etc.**) YES NO
   If "Yes" list vaccine type:_____ date:_____
7. Has your child ever had recurrent wheezing or a history of asthma at **any time in his or her life**? YES NO
8. Is your child receiving long term aspirin or aspirin-containing therapy? YES NO
9. Does your child have diabetes, kidney, heart or lung disease? YES NO
10. Does your child have a weakened immune system?
    (ie.: from cancer drugs, high dose steroids, HIV, etc.) YES NO
11. Will your child be around a person who has a severely weakened immune system?
    (ie. recent bone marrow transplant, or is in protective isolation) YES NO
12. Is there a chance that your child is pregnant? YES NO

The Westford Health Department Nurses will review this information before vaccination. We reserve the right to NOT vaccinate your child if you have not filled in the questionnaire completely or if we determine that your child has a condition that prevents him or her from safely receiving this vaccine **in a school setting**. If we are unable to vaccinate your child, you will be notified by the Westford Health Department prior to vaccination day.

I have read the 2010-2011 vaccine information statement for Live Intranasal Influenza Vaccine and understand the risks and benefits. I give consent for the Westford Health Department to administer FluMist Nasal Influenza Vaccine to my child listed above.

Signature of Parent/Guardian:_____ Date:_____

Print Parent/Guardian Name:_____ Phone:_____

Return Forms to the Westford Health Dept. (**NOT** to your child's school).

By mail: 23 Depot Street, Westford MA 01886

Or drop off: 8am-4pm at the Health Dept Office in the Millennium Bldg., Rm 10

Have questions? Call 978-692-5509